Submission to the General Insurance Code Governance Committee's Monitoring Priorities 2025-26 Consultation

Date of submission: 7 February 2025 *(Amended 5 March 2025)*

About Financial Counselling Victoria

FCVic is the peak body and professional association for Victoria's 300 practising financial counsellors. Our organisation was established in 1978 by Victorian financial counsellors to provide sector professionalisation, peer support, and undertake systemic advocacy.

FCVic's vision is *'a fairer and more equitable society with improved community wellbeing and better lives for vulnerable people'*. FCVic develops resources, builds sector capability, and advocates on behalf of financial counsellors and community members on systemic issues that cause and exacerbate poverty and financial hardship. We work with government, banks, utilities, debt collection agencies and other industries to improve approaches to financial hardship and vulnerability.

Financial counselling is a free, confidential, and independent service. It provides vital help for people experiencing, or at risk of, financial hardship. Financial counsellors are uniquely qualified professionals, specially trained to deal with complex financial matters. They assist more than 23,000 Victorians each year – including newly arrived migrants and refugees, family violence victim-survivors, and particularly pertinent to this consultation, people impacted by catastrophic natural disasters.

About this submission

We welcome the opportunity to provide a submission to the General Insurance Code Governance Committee's (GICGC) Consultation on 2025-26 Monitoring Priorities.

This submission has been informed by the input of disaster recovery specialist financial counsellors, through a consultation process through FCVic's Insurance Working Group. We acknowledge and give special thanks for their input and expertise which has helped to inform this submission.

The commentary and recommendations provided in this submission should be read in conjunction with a wide body of work already produced by FCVic (in conjunction with our advocacy partners) on issues relating to the handling of insurance claims, including:

- Research Report - Unsettled: Climate risk and cash settlements in home insurance
- Submission to the Independent Review of the 2020 General Insurance Code of Practice
- Submission to the House Standing Committee on Economics Inquiry into insurers' responses to 2022 major floods claims
- Submission to AFCA's joint consultation on General Insurance Approaches

- Submission to Treasury's consultation on Standard definitions and standard cover for insurance
- Submission to the Inquiry into Climate Resilience

In particular, we draw your attention to our submission to last year's GICGC consultation on 2024-25 Monitoring and Compliance Priorities, the recommendations of which are still relevant this year and will be reiterated in our commentary below.

We note that the national peak body Financial Counselling Australia has also provided a submission to this consultation. We support their recommendations, and suggest that our submission be read in conjunction with theirs.

Further questions about this submission can be sent to Kellie Davis, Disaster Recovery Lead at FCVic, at kdavis@fcvic.org.au.

Note – this submission uses the words clients (of financial counsellors), customers (of insurance companies) and consumers (of insurance products).

Our commentary

Specialist disaster recovery financial counsellors working with clients recovering from floods, storm events, and bushfires (in some cases, multiple events), have consistently identified significant consumer issues relating to insurance claims.

Despite ongoing advocacy including multiple reports and complaints to regulators, insurers continue to demonstrate poor treatment of customer vulnerability and transparency during claims processes. The failure of Code subscribers to recognise and appropriately support customers has exacerbated the trauma of going through these significant disaster events, causing additional harm and delaying recovery.

Case study from a financial counsellor

A culturally and linguistically diverse client had both their home and business premises severely damaged by a storm in January 2023. The insurer denied their claim on the basis of maintenance issues, which the client disputed.

English was a second language for the client, who repeatedly told the insurer that they did not understand the claims process. Despite this, the letter of denial from the insurer was very complex, and required the client to refer to several different documents as the basis for the claim denial. The claim was then closed.

The financial counsellor intervened, and the claim was reopened. Upon reviewing the letter of denial, even the financial counsellor had difficulty understanding its contents.

The financial counsellor successfully argued that the insurer had systemically breached customer vulnerability support requirements throughout the entire claims process, including a failure to acknowledge that the client had no capacity to undertake repairs themselves. The financial counsellor also identified the reports relied upon by the insurer were inconclusive desktop assessments.

The insurer agreed to accept and settle the claim and complete the repairs. They acknowledged the severe impact the protracted claim had upon the client's mental health and earning capacity, and some non-financial loss was agreed upon.

Unfortunately, the issues raised in our submission last year and the associated recommendations are still relevant – financial counsellors have seen no improvement.

We are particularly concerned by the recent Code of Practice breach of January 2025, relating to failures in the handling of customer claims and complaints, where the insurer was not named. The decision to not name this insurer because of their 'model response' is misjudged. Publishing details would highlight to consumers that accountability matters, and provide assurance that the Code is designed to protect consumers, not to protect the reputation of insurers.

Publishing details is not unusual for compliance and regulatory bodies. The Essential Services Commission in Victoria consistently publishes full details of the regulatory action they take, including the names of service providers and their actions that have led to the financial penalties. Similarly, AFCA decisions also publish names and case details, and the factors that have influenced the final decision. We urge the Code Governance Committee to follow this lead to increase transparency and accountability.

As such, we reiterate that last year's recommendations, especially Recommendation 1 relating to publishing details of Code breaches, should be retained for consideration by the GICGC:

Recommendation 1: That the Code Governance Committee publish details of Code breaches, including the name of the code subscribers.

Recommendation 2: That the Code Governance Committee issue a guidance note to Code subscribers to support the consistent implementation of Part 9 of the Code, with regard to defining, identifying and supporting customers experiencing vulnerability. The guidance note should consider the impacts of trauma following a significant event on cognitive capacity, and the extra care and additional support for customers that this may entail.

Recommendation 3: That the Code Governance Committee issue a guidance note to Code subscribers to support the consistent implementation of Part 8. The guidance should provide clear advice regarding

- paragraph 61, what constitutes a reasonable number of scopes of works, and what is an accessible scope of works;
- paragraph 75, the sharing of details of relevant expertise, qualifications and breakdown of costings of contractors used in assessments; and
- paragraph 64, how "urgent need" is determined, and the best practice time frames for fast tracking a claim following a natural disaster.

Recommendation 4: That the Code Governance Committee issue a guidance note to Code subscribers relevant to Part 12 (162) on the provision of information to customers

relevant to their claim, regarding the breakdown of costings, and any uplifts comprised in an offer.

Insurers delaying claims

Further, financial counsellors have observed that as claims have progressed over the past year, several insurers remain in dispute on claims until an AFCA complaint is lodged. The insurers will then settle on the customer's proposal without amendment in the early stages of the AFCA process before the complaint proceeds to determination. This practice appears to be deliberately designed to 'wear down' the customer's resolve until they accept an unreasonable settlement.

Case study from a financial counsellor

A not-for-profit organisation presented to a financial counsellor for assistance. They had been providing housing to over 20 vulnerable people, but half the units were inundated with flood water, leaving 12 elderly people homeless.

The NFP client's insurance claim was denied on the grounds of co-insurance, with the insurer pushing for a cash settlement. This was disputed, and a letter of complaint was sent to the Insurer, setting out grounds of full cover and requesting that the insurer undertake repairs as the NFP client had no capacity to do so. The insurer did not respond.

After 15 months of negotiations, the financial counsellor supported the NFP client to lodge a complaint to AFCA. The insurer immediately accepted the client's position and agreed to full building reinstatement, full contents replacement costs, payment in full of business interruption cover until the rebuild was completed, and non-financial loss payments and penalty interest claims.

This only happened after the AFCA complaint was lodged, but before it progressed to determination. While the rebuild was completed within eight months of this point, the insurer's actions left elderly and vulnerable people unnecessarily homeless for over two years.

We note that these claims are strategically settled before an AFCA determination – as such, they are not published, and there is therefore no public accountability for the insurer's actions in delaying claims.

Case study from a financial counsellor

A business owner client was impacted by severe flooding in their Victorian town in October 2022. They also owned some investment properties in the same town, and so were managing three claims directly with the same insurer.

During this claims process, there were significant delays in 'make safe' works and Scope of Work corrections. In February 2024, months after the disaster event, the insurer

proposed a cash settlement based on the insurers' builder's quotes. The client declined this settlement as they knew the quotes weren't actionable.

The client expressed their loss of faith to the insurer and pointed out the considerable delay in settling the claim. The client advised the insurer they were exhausted and that the ongoing burden of the dispute had impacted their mental health. The client proposed a cash settlement based on a builder's estimate of repairs to similar properties, without fully understanding all their entitlements. The client requested the insurer settle or "we take the cases to the insurance ombudsman". After 15 months of the claim being in dispute, the insurer finally settled due to the risk of the client taking the matter to AFCA.

Coupled with the common requirement of insurers during negotiations for customers to sign non-disclosure agreements (NDAs) for the claim to be settled, this essentially results in the concealment of the facts of many substantive claims that could have set precedents for what consumers can expect.

There is no good reason for NDAs to be required in insurance claim settlement agreements. Settlements are, by requirement, fair and reasonable. We suggest that NDAs are being wielded by insurers to silence consumers who have been able to fight for their rights, to prevent other consumers from learning from precedent cases about their entitlements.

We reiterate the importance of publishing Code breaches (Recommendation 1), publishing other claim statistics, and the issuance of guidance notes on best practice use of NDAs.

We note that Code Review Panel considered Recommendation 48 of the Federal Parliamentary Flood Inquiry[1] and Recommendation 96 of the Code Review[2] to be 'broadly consistent'. We do not consider these two recommendations to be consistent – publishing names alone does not provide the richness of data that is required to act as a deterrent on delaying tactics, provide transparency on insurer behaviour, or provide guidance on case precedents for future claimants and consumer advocates. We support Recommendation 48 as the option that is most likely to lead to sector-wide improvements.

Recommendation 5: That the CGC publishes breaches, and AFCA publish **comprehensive** statistics by Insurer, showing at what stage claims are settled in accordance with Recommendation 48 of the Federal Parliamentary Flood Inquiry.

Recommendation 6: That the CGC issue a guidance note on best practice use of non-disclosure agreements in settlements, with instructions for use only where there is a demonstrated need for commercial confidence.

[1] The Committee recommends that the General Insurance Code Governance Committee publish aggregate data on code breaches by clause, individual insurer, and brand.
[2] The CGC should publish insurer names in regular compliance and data reports.

Temporary accommodation provisions

Related to these seemingly deliberate delays on the part of insurers when handling claims, is the significant detrimental impact on customers who are in temporary accommodation due to their experience of disaster events.

Financial counsellors hold significant concerns about the current cap on temporary accommodations. As we stated in our submission to the Code of Practice Review:

> *We hold significant concerns about the timeframes noted in item 78 – especially in relation to 'Extraordinary Catastrophes'. Financial counsellors report seeing cases where insurers are 'waiting out' the consumer's access to 12 months of temporary accommodation provisions under the Insurance Contracts Regulations 2017. When this provision is exhausted, the insurer either breaches the Code by going over the existing timeframes, or uses this against the insured to force cash settlement of claims, offering no uplift for contingencies or transfer of risk. Amendments should be made to the Code to shorten the timeframe to avoid the second outcome, and increasing penalties applied to avoid the first outcome behaviour.*

The impacts to customer vulnerability are evident. While there are limitations to the definition of vulnerability in the current Code, it is clear from financial counselling practice that clients in temporary accommodation following a disaster event will experience multiple and compounding vulnerabilities including significant trauma and mental health concerns, severe financial hardship, and other socio-economic impacts.

Ending temporary accommodation funding prior to final full claim settlement and completed rebuild of the original accommodation is clearly not:

- taking extra care with customers who experience vulnerability (paragraph 91 of the Code)
- engaging with sensitivity, dignity, respect and compassion (paragraph 96)
- a suitable, sensitive and compassionate way for insurers to proceed (paragraph 97)
- treating people with any past or current mental health condition fairly (paragraph 104).

Case study from a financial counsellor – please refer to Appendix A for a detailed case study.

We are disappointed that the Code Review Panel reiterated the 12-month cap in their Recommendation 69, and are more in favour of the recommendation from the Federal Parliamentary Flood Inquiry which notes that temporary accommodation should be paid until the insurer has closed the claim. The CGC should provide clear guidance on how temporary accommodation should be managed in insurance claims, with particular reference to customer vulnerability.

Recommendation 7: That the CGC issue a guidance note that clarifies that where the delay is caused by the insurer, that temporary accommodation entitlements are extended until the final handover of the fully reinstated building.

The guidance note should also make reference to customer vulnerability – for instance, noting that temporary accommodation entitlements should not cease if the client is at risk of homelessness as a result.

Insurers' acceptance of external expert reports

Financial counsellors are reporting systemic issues with insurers not accepting external independent expert reports / quotes in disputed claims, instead relying upon their own trade / expert reports which are typically less comprehensive and realistic than the independent reports / quotes. This leads to unreasonably prolonged claim disputes, and poor settlement outcomes for customers.

This is particularly problematic given the obvious bias of insurers' trade / experts due to commercial concerns. We noted this and other concerns relating to 'inhouse' expert reports in our submission to the Code of Practice Review:

> *The experience of financial counsellors demonstrates that service suppliers and agents appear to be motivated by retaining the contract with the insurer rather than providing a high level of service to the consumer. As such, this leads to a perceived conflict of interest, that the supplier is motivated to reduce the expenditure rather than providing a quality and fully detailed service. ....*
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> *We have seen situations where assessors have provided sub-standard and vague reports that insurers then use to determine claims. The difficulty for the average consumer in disputing these reports through channels such as AFCA (who tend to rely on these 'expert' reports), is notable. There is a requirement for a high level of advocacy skills, comprehension, and capability to manage these disputes. ...*
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> *Financial counsellors report that 'expert reports' are often worded in a way that:*
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> - *Is vague on causation of damage, and liability, especially with regards to alleged pre-existing conditions and lack of maintenance, and ground movement;*
> - *Makes the report appear conclusive rather than opinion; and*
> - *Implies that there is no point in challenging the outcome.*
>
> ...
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> *Currently, the only way for a consumer to dispute an expert report is to source and commission their own expert report – in some cases, multiple reports. There are limitations to this, not only from the perspective of a financial barrier and a personal capacity barrier, but also in terms of sheer availability of appropriately qualified experts. Additionally, independence is important, however finding one not engaged by an insurer can be difficult.*
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> *We believe that the Code must allow for opportunities to dispute the findings of a report in a way that is not financially prohibitive for the consumer. An opportunity for substantial reform to strengthen independence in expert reports is to require insurers to source expert reports from an independent body. Another opportunity,*

though less innovative, is to establish an independent expert panel who can review existing reports where a dispute arises.

Financial counsellors note that when taking complaints to AFCA for deliberation, AFCA will typically give more weight to external expert reports commissioned by the customer, as it is considered more truly independent than those commissioned by the insurer.

We have evidence from an independent engineer who has been providing expert reports to support disaster-related insurance claims that of the 17 most recent reports they have completed, ten have been found by AFCA to be in the client's favour, and the remaining seven await determination. This is clear evidence that independent expert reports more accurately demonstrate causation and damage to a client's property than insurers' own reports.

Locations	Event	AFCA Outcome
Rochester	Flood	In favour of client
Rochester	Flood	In favour of client
Rochester	Flood	Still under decision
Rochester	Flood	In favour of client
Rochester	Flood	In favour of client
Echuca	Flood	Still under decision
Rochester	Flood	Still under decision
Rochester	Flood	In favour of client
Heidelberg West	Earthquake	In favour of client
Carrum Downs	Earthquake	In favour of client
Lalor	Earthquake	In favour of client
Brunswick	Earthquake	Still under decision
Rochester	Flood	In favour of client
Park Orchards	Fire	Still Under Decision
Box Hill	Fire	Still Under Decision (Close to client preferred outcome though)
Bendigo	Storm	In favour of client
Wonga Park	Storm	Still Under Decision

We note that the *AFCA Approach to proximate cause of damage* states 'AFCA will ensure that all expert evidence submitted is exchanged with the other party, and will critically review the expert evidence, in making a decision about what is fair in the circumstances', with 'fair' defined as '*we apply a standard of fairness which focuses on fair dealing, fair treatment and fair service. This allows us to assess the conduct of a financial firm over the life cycle of the firm's relationship with its customer*'.

This measure is one that should be promoted by the CGC and adopted by Code subscribers to ensure consistency of approach in evaluating external expert reports.

Recommendation 8: That the CGC issue a guidance note on industry-wide consistency in the decision-making process in evaluating external expert reports, with the standard of 'balance of probabilities' to be applied where there is conflicting information.

Thank you for the opportunity to provide this submission to the GICGC Consultation on behalf of Victorian financial counsellors who each year, assist over 23,000 vulnerable people experiencing financial hardship.

Appendix A: Case study from a financial counsellor

Client Background

Tony* is a 67-year-old man who was living with his 97-year-old mother Sara* (as her primary carer) and his 65-year-old brother Kevin* at the time of the floods.

Tony had moved into Sara's home after the passing of his father to be her full-time carer. Kevin suffers from mental health issues and is substance-affected.

Tony and Kevin are in receipt of Centrelink benefits. Approximately one month after the October 2022 Flood, Sara passed away with Tony being the executor of her estate.

Kevin's rental property was insured but did not have flood cover. Sara's property was insured. Tony also owns a property which he rents out and was flooded without insurance.

Presenting issues

Sara has a reverse mortgage on the home of approximately $600,000 accruing interest at approximately $5,000 per month. Tony was concerned about what may happen since Sara had passed away and that any equity in the property/estate was being consumed by interest due to the delays of the insurer.

The insurance claim on Sara's home was accepted in February 2023, however the property had not been stripped out or dried – this did not occur until August 2023. Tony was concerned that the mould in the home was spreading to the second story which had not been impacted by flood waters during the event.

At presentation to a financial counsellor, Tony explained that he was staying in a family friend's holiday home and his brother Kevin was being supported by someone else for accommodation.

Casework Summary & Outcomes

Temporary accommodation:

With support of the financial counsellor, Tony was provided 12 months temporary accommodation, this was then provided again covering two years total.

When the first 12 months accommodation expired, Tony had to evict the tenants from his home so that both he and his brother Kevin had somewhere to live.

The financial counsellor is still negotiating with the insurer for an additional extension of this second 12 months, given repairs are yet to be completed to a liveable condition. During this negotiation period, the insurer has conducted an audit of the temporary accommodation provided asserting that it was not required because Tony would have just moved into his rental property when his mother passed away, not considering that the property can't be sold.

The insurer is reviewing delays allegedly caused by Tony for engaging sub-contracted trades to complete other works at the property (on the second floor). They assert this caused delays in completion of repairs, despite trades advising Tony they had not been paid and would not return until they had been paid by the insurer's building contractor.

Repairs:

A scope of works was only produced in September 2023 to the financial counsellor however it had not been signed. Additional variations were required as many rooms' repairs had been missed. A final scope was signed in March 2024 with repairs commencing in April 2024.

The expected completion date for repairs was May 2024, then August 2024. In August 2024, the financial counsellor met with Tony at the property to review the repairs and those yet to be completed. A significant list of works not in the scope and those that were either not completed or completed to sub-par standard was sent to the insurer.

In October 2024, the insurer advised the financial counsellor that the property was habitable, despite having been advised by Tony that there was no running water, no light fittings, no toilets, oven or stove, empty water tanks and no access to mains power.

The insurer organised a virtual internal assessor to attend the property, but this was declined due to the size of the property and the lack of internet/phone reception. Subsequently an on-site visit was held with the insurer, the insurer's building contractor, Tony and the financial counsellor. At this visit, the estimated completion date was amended to mid-December 2024. Since this visit it was extended again to end of January 2025 and is still yet to be completed.

Tony has found the process debilitating to his mental health and costly to his mother's estate and its subsequent beneficiaries. Throughout the process, the insurer's building contractor has consistently failed to pay trades invoices which resulted in them refusing to attend the property until payment was received. Low quality white goods had been returned, theft of water pumps occurred at the property and the insurer's building contractor has been difficult to reach with little engagement with Tony.

Reverse Mortgage:

The bank agreed to provide 12 months of 0% interest on the mortgage, however at the cessation of this, they refused to provide any further support. This has meant a significant increase in the mortgage balance.

This has been difficult for Tony to comprehend given that the bank sold the insurance to Sara at the time she took the mortgage out.